Issue BRIEF

Health Plan Liability Issues

Executive Summary: Many states have drafted and introduced legislative changes to their tort laws that would expose health plans, like HMOs, to liability for their coverage determinations and utilization review activities. Additionally, current proposed federal legislation contains provisions that would allow consumers to bring tort actions for wrongful death and personal injury under state law against health plans which contract with insured and self-insured employee benefit plans governed by the Employee Retirement Income Security Act (ERISA).

In 1997, New York moved forward on a health plan liability bill that permits HMOs to be liable for personal injuries resulting from a failure to approve, provide, arrange or pay for covered services in a timely manner. A proposed California bill that would impose liability on health plans for injuries caused by its employees, agents, or ostensible agents has gained momentum toward becoming law in that state. In addition, Texas enacted a law that allows plaintiffs to bring state tort actions against health plans for their health care treatment decisions.

Proposed federal legislation, like the Patient Access to Responsible Care Act of 1997 ("PARCA"), contains a series of regulatory mandates and requirements for private sector health plans. PARCA also allows consumers to bring state law claims for wrongful death or personal injury against insured and self-insured ERISA plans.

The liability provisions contained in these various bills will not benefit patients and will not improve health care quality. Instead, they will (1) expose patients to questionable care, (2) raise costs by undermining the cost containment mechanisms that have only recently brought health care expenditures under control, (3) reduce the availability of types of health plans that many patients have chosen, and (4) suppress new and better ways of organizing health coverage. Employers and consumers will be forced to bear the brunt of administrative cost increases associated with increased liability insurance and litigation, invariably leading to the loss of health care coverage for some individuals. Moreover, the health care system will become more adversarial, alienating consumers, health plans, and providers.

American Association of
HEALTH PLANS

1129 20TH STREET, NW, SUITE 600
WASHINGTON, DC 20036-3421 • (202) 778-3200

Health Plan and Provider Roles

There has been considerable discussion of providers' and health plans' roles in medical decision-making. In our view, plans' and providers' roles are related, but not identical.

The major roles of health plans are to develop and maintain panels of qualified providers; to offer resources that support providers' activities; to safeguard and maintain the financial resources needed to pay for patients' health care; to operate quality assurance programs to benefit consumers; and to make decisions about coverage - that is, about when a particular service or category of services falls within the scope of the benefits financed by its premiums and agreed to by contract.

Health plans are held accountable for the benefits coverage they provide through extensive statutory licensure requirements, regulatory requirements, voluntary accreditation standards, and consumer demands in a competitive marketplace. These include:

- the requirements of the Federal HMO Act;
- standards for health plans participating in Medicare, Medicaid, and the Federal Employees Health Benefits Program (FEHBP);
- state regulatory and licensure requirements; and
- standards for private-sector accreditation.

Failure to comply with such requirements can result in sanctions and penalties. Similarly, health plans that fail to live up to their contractual obligations for benefits coverage may be subject to civil lawsuits for breach of contract.

In contrast, the role of physicians and other health care providers is to render clinical health care to patients consistent with their state licensure category and their independent professional judgment. They are held accountable for their patient care decisions and acts under state law through medical provider board licensing activities, and by other mechanisms, such as peer review by hospital staff and other entities. They are also subject to state tort actions brought by patients they treat for negligence and medical malpractice.

Health Care Costs Will Increase

Expanding state tort liability to health plans will cause health care costs to rise. The costs of increased litigation -- attorneys' fees, administrative costs, the costs of defensive coverage determinations, liability insurance premium increases, unlimited jury verdicts -- will inexorably increase the cost of health care. This will lead to higher premiums, higher out-of pocket costs, and less choices of coverage for consumers. It also will lead to more uninsured Americans.

The costs associated with the medical malpractice system are staggering. Total spending for malpractice insurance was estimated in 1991 at over $9 billion (Lewin-Meyer). More significant are the costs of defensive medicine -- services without benefit to patients that are provided to avoid malpractice claims -- estimated by various sources as somewhere between $10 and $20 billion a year. A recent Stanford University study of defensive medicine found the costs for

treating coronary artery disease grew more than twice as much in states that lacked the tort reform necessary to curb defensive medicine. The researchers found that in states with weak or no limits on malpractice liability, spending on heart attacks rose 24 percent -- with no benefit in terms of health outcomes. In fact, there is no evidence that the medical malpractice system contributes significantly to patient safety or quality of care.

Federal and state laws that would make health plans liable for coverage determinations and utilization review activities will raise costs to employers and consumers without providing meaningful benefit:

- **In much the same way that physicians have been forced to practice "defensive medicine," health plans will be forced to provide coverage for unnecessary services that do not benefit, and may even be harmful to, patients in order to avoid costly litigation.** Instead of making medical appropriateness decisions based on scientific evidence and objective best practice protocols, health plans will be influenced to make these decisions based on the latest jury verdict or court decision. Extending medical malpractice or other tort liability to health plans will only foster greater litigation and drive the costs of defensive medicine to new heights by subjecting plans to the same "more is better" incentives that providers often pursue in an effort to insulate themselves from potential liability.

- **Increased litigation will undermine the very methods which have made health plans successful at delivering affordable, high quality care.** Methods such as quality assurance programs, utilization management, provider payment structures, and provider credentialing will be attacked as the proximate cause of alleged injuries. Additionally, aggressive litigation tactics will be used to circumvent coverage limitations clearly defined in plan documents. This, in turn, will undermine health plans' and employers' ability to contractually fix the range and scope of coverage to be provided.

- **A return to rising health care costs will ultimately reduce access to health benefits.** Employers, confronted with unaffordable health benefits costs, will be forced to reduce or eliminate coverage for employees, resulting in more uninsured Americans. With each 1 percent increase in premium costs, small business sponsorship of health insurance drops by 2.6 percent (Morrisey et al., 1994) and 200,000 Americans lose coverage (Congressional Budget Office, 1996).

- **Failing to provide any meaningful standards for physicians' acts which are the trigger for lawsuits against health plans.** A physician's treatment and recommendation that gives rise to a legal action is not required to meet any identified standard of care, or to make a showing to the plan that the recommendation is appropriate. Even clearly erroneous recommendations could trigger a lawsuit. Conversely, a health plan that follows recognized protocols in making its coverage decisions will receive no protection against suit.

Failure of the Medical Malpractice System

The current tort system for resolving medical malpractice claims has been rightly criticized

by physicians and others as inefficient, expensive, and frequently, of little benefit to those who have been injured. Expanding state tort law to subject health plans to lawsuits for its coverage decisions will simply make matters worse.

The medical malpractice system is an arbitrary and costly system. Only 43 cents of every dollar spent on medical liability litigation reaches injured patients as compensation, according to a recent Rand Corporation study. Too often, the medical malpractice system fails to provide relief to injured patients who deserve compensation, while inappropriately rewarding those who do not. Researchers at Harvard University studying patients hospitalized in New York in 1984 found that persons injured by medical malpractice were frequently not compensated, and that many lawsuits involved cases in which there had been no injury or no negligence. As a result, the medical malpractice system has become an uncertain "litigation lottery" -- rather than a mechanism for providing fair and timely compensation to the injured.

Over the last decade, virtually every state legislature has enacted some type of tort reform designed to limit medical liability. In doing so, legislators have acknowledged the serious flaws in the medical malpractice system and the need for limiting access to it. Such reforms would be undermined if states and the federal government begin to enact laws that would encourage more, not fewer, lawsuits. This is especially true in light of the fact that many of the state proposals to expand tort liability to health plans do not provide protection to health plans in the form of limits on damages and other procedural safeguards that are present in state tort reform laws applicable to providers.

Maintaining Uniformity Under ERISA

Proposed federal legislation affecting ERISA will undermine the uniformity provided by ERISA for multi-state employee benefit plans and will promote increased liability and costly litigation.

PARCA would make ERISA's preemption provision inapplicable to "any State cause of action to recover for damages for personal injury or wrongful death against any person that provides insurance or administrative services to or for an employee welfare benefit plan maintained to provide health care benefits". This bill exposes health plans and other insurers, their employees, administrators, employers voluntarily offering health benefits to employees, and any anyone else involved in the business of providing or arranging for health benefits coverage to state tort liability. PARCA and other such bills will undermine the uniformity provided by ERISA for multi-state employee benefit plans, requiring these plans to adopt their practices in reaction to the statutes and court decisions bearing on the liability issue in the many states in which the plan may operate. This only will increase costs of plan administration with no resulting increase in health care quality.

ERISA does permit beneficiaries to seek recovery of benefits.

ERISA plan beneficiaries already have the right to seek to recover benefits they believe they are entitled to under an employee benefit plan. Moreover, they need not wait for an injury to occur to seek recovery. An ERISA participant or beneficiary who believes that he or she has wrongfully been denied coverage of a benefit may seek injunctive relief in the form of a court order to have the benefit provided long before any injury is sustained.

Adding More Lawsuits Is Not the Answer

Expanding malpractice liability to health plans will not promote the public welfare. Health plans do not make clinical treatment decisions -- these matters are properly reserved to physicians and their patients. Putting disputes over benefits coverage and appropriateness findings into the tort system for resolution would be costly to patients, extending the time for resolution and burdening an already overwhelmed judicial system. In fact, government sponsored programs under the FEHBP, which provides health benefits coverage to more than 9 million Americans, significantly limit the availability of civil causes of action against health plans in favor of other means for resolving disputes.

Recent research suggests that in a majority of cases, concerns about adverse coverage determinations are resolved in favor of consumers through health plans' internal processes. A 1995 study of 2,003 U.S. physicians nationwide (Remler et al., 1997) found that for all procedures surveyed (including hospitalizations, surgical procedures, specialist referrals, substance abuse treatment, mental health referrals, MRIs, endoscopies, and cardiac catherizations), initial denial of coverage was always less than 6%, and that more than 60% of these initial denials ultimately were approved by the health plan through its internal appeals procedures.

What is needed is expeditious, accessible processes for resolving disputes. A more appropriate means for meeting consumer needs than increased exposure to litigation is to ensure that patients to have fair access to fast, fair, and efficient processes and procedures for resolving disputes or grievances about their health care. Health plans are committed to achieving this through effective quality improvement programs, accreditation, and risk management programs. Additionally, AAHP member health plans have committed themselves through *Putting Patients First* to appeals processes which provide timely notice to a patient when an adverse coverage recommendation is made and which include an easily understand description of the patient's appeal rights. As part of this process, AAHP member plans are committed to providing an expedited appeals process when the normal time frames for an appeal could jeopardize a patient's life or health.

Conclusion

Health plans have demonstrated a strong commitment to accountability for high quality health care through effective quality improvement systems, accreditation, and risk management programs. Making health plans the target of state tort claims for coverage determinations or utilization review activities will seriously threaten the affordability of health care with no improvement in health care quality.